justly distributing resources

Laurence Crutchlow explores difficult decisions in healthcare

'Postcode lottery!' soon appears in the media[1] when local decisions about healthcare resources are compared, even though public demand for services 'closer to home' makes such differences inevitable. Health and funding decisions cause much controversy in the UK, with the so-called 'dementia tax'[2] playing a big part in the 2017 General Election, as did the 'war of Jennifer's Ear' 25 years before in 1992.[3] How can we apply Scripture to these controversies?

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biblical principles

everything comes from God

'Everything comes from you, and we have given you only what comes from your hand' (1 Chronicles 29:14). Resources, whether natural, financial, time, or emotional are given to us by God; when giving to his work, we are simply giving back to him. David's words above sum up this most important truth about resource allocation. Humans have been expected to manage resources from the very outset.[4]

there are not (now) infinite resources

With the perfect pattern of Eden broken, it becomes apparent work will be needed to produce resources such as food, and it will be hard.[5] While the words of both Isaiah 65 and Revelation 21 and 22 suggest that there will eventually be a time of unlimited resources, this is not yet!

care for the poor

Israel was expected to distribute tithes among the poor,[6] with care for the poor also clear elsewhere in the Law.[7] The prophets clearly expect Israel to care for the poor.[8] The links between poverty and health seem well established today,[9] and this might indicate at least that the church should be aware of the health of the poor.

Later on, the early church got involved in social care for its members,[10] and since then, there has been a rich history of Christian involvement in providing healthcare.[11]

we are all created equal

If we have been created equal in God's sight, people ought to be valued equally when difficult decisions are made. This does not mean that everyone gets the same; what is helpful to one person may be very unhelpful to another. But we start from an assumption of people having equal intrinsic value.

Some of the application of this should be obvious – non-discrimination on grounds of age, sex, race, or religion. But it also calls into question a rather more common suggestion – discriminating against those perceived to have 'caused' their illness.

forgiveness is central to Christian life

'Forgive us as our sins, as we forgive those who sin against us' is prayed countless times. Does this forgiveness always extend to the causes of disease? How do we deal with the patient with repeated STIs who will not alter their behaviour, or the heavy smoker with deteriorating COPD? Do we subconsciously treat lung cancer patients differently from those with brain tumours? There are still indications that the general public might expect us to do so.[12] Some UK government advertising during the COVID-19 pandemic has, at least in the eyes of some,[13] appeared to come very close to blaming victims for becoming infected.

None are without sin.[14] So surely discrimination based on why someone might have contracted a disease is antithetical to a gospel of redemption and forgiveness, not to mention hard to prove conclusively. Who is to say the 40 pack-year smoker wouldn't have been one of the unlucky few who was going to get lung cancer anyway, smoking history or not?

These principles clearly don't give immediate answers to 'which patient gets their new knee next?', or 'should our hospital buy these more comfortable but much more expensive scrubs for theatre?', but they do offer a framework that might guide us as we think through what may sound like secular questions about how resource allocation works.

what system might allocate resources best?

Many say 'spend more on health'. But there will be pressures in any system. A government system can

only spend what it can raise in taxes. A mutual insurer can only charge premiums that customers are willing to pay. So, there will be rationing in every healthcare system. In a purely free market, this is simply via ability to pay – but such systems are very, very rare. Most health systems are insurance based; an insurer could be a wholly private company, or as in the UK, be effectively an arm of the government, or something in between. Nonetheless, that insurer must decide what the limits of its cover are; for example, will it prioritise a treatment that cures a few, or one that gives partial relief to many? What about a tablet demanded by patients, but with limited evidence base? How much should be spent to make it easy to see a doctor for a long-standing rash at 9 pm on a Sunday?

These decisions are no different whether that insurer is a private company, the government, or a mixture of both. Someone still pays (whether this is customers, employers, or taxpayers), and the insurer still needs to satisfy patients (whether that is direct customers, or voters where the government is the insurer). The questions don't change however the system is constituted, and this is why I have not further considered what system might work best in this article, but instead focused on the choices that system must make.

how should a system allocate resources?

A number of questions can be asked. These may seem obvious but can help us to plan.

does it work?

Many treatments previously widely used based on intuition or experience have limited clinical effect. Tonsillectomies, particularly in children, are often not effective[15] (although this is itself disputed).[16] Cervical screening for under-25s in the UK was not only a poor use of resources but probably a source of clinical harm.[17]

The efficacy of expensive new treatments may be uncertain.[18] Eventually a threshold must be set where a treatment is considered not effective enough to fund, with the exact limit probably depending on overall resources. Though apparently fair, this can lead to challenging cases, often in younger oncology patients. The UK has tried to work round this through the 'Cancer Drugs Fund', though this in itself has been controversial.[19]

Spending money on something that doesn't work seems a poor use of God-given resources.

is it a priority?

Challenges here include surgery for conditions which are 'abnormal' but should have limited impact on a patient's life – for example mild *pes excavatum*. In-vitro fertilisation treatment is often questioned in the UK – even though success rates are improving,[20] and most would agree that infertility is a disease that we would investigate and treat. How much pain does an arthritis patient need to have before a hip replacement becomes a high priority?

The answers will depend on what resources a system has. It is hard to judge the worth of a particular treatment, which may vary from patient to patient. If efficacy is similar, it is probably better to focus on specific outcome measures, such as improvements in validated symptom scores, to work out where priorities should lie.

Using evidence-based measures where possible will mean that we are less likely to be tempted to discriminate between different groups, or against those who are thought to have contributed to their own illness.

might it be cost-saving?

What about treatments that may themselves save other resources? Early cancer diagnosis ought to reduce costs even if investment is needed in a screening programme (though it is important to carefully evaluate such programmes as these can easily do more harm than good). Funding a training course in infection control that subsequently reduces post-operative infection is good for the patients concerned as well as for costs.

Wider public health measures such as vaccines,

or clean water, may have a lot more impact than more 'medical' interventions. Even the state of the economy itself matters, knowing that poverty and poor health are linked.

Using resources well can legitimately include 'spending to save', although the source of funding must be considered carefully, particularly as interest payments if money is borrowed may reduce expected savings.

what happens when a system is overwhelmed?

A well-managed system should ensure that decisions about resources concern particular *treatments*, rather than particular *patients*. This should largely avoid issues of discrimination, whether around personal characteristics or the perceived cause of the disease, although doesn't stop a broader decision about a particular treatment having a disproportionate effect on a particular group.

But even in a well-resourced system, there may be crises. The COVID-19 pandemic has illustrated this starkly. The UK poured vast (borrowed) resources into the system. New hospital capacity was built, ventilators hurriedly procured, and draconian restrictions on freedom and the economy led to huge costs for economic support. Yet even spending at this level doesn't solve all problems. Skilled staff cannot suddenly be produced, whatever the number of beds theoretically available; both restrictions on the population and reprioritisation within healthcare increasingly appear to have had a significant impact on dealing with other disease, such as cancer.[21]

I suspect that a key motivation for the government in approaching COVID-19 this way was to try and minimise situations where a doctor would have to choose which of two similar patients got the last available ventilator or ITU bed. CMF has produced a paper considering what we should do in that situation.[22]

how can we decide between individuals?

It is very rare that two patients will have an identical chance of getting the same benefit from a treatment. Scoring systems that incorporate factors like age, co-morbidities, and severity of illness at the time of decision may help make decisions as to who will benefit more consistent. These will never be foolproof, and almost all of us with even limited experience in medicine will remember patients who have done much better than anyone would have expected, or sadly have died when it seemed unlikely that they would.

Sometimes, such choices may look discriminatory. Often younger patients do benefit more from treatment than older ones. Smokers are often likely to respond less well. But such decisions are still being made on clinical grounds, not on the perceived value of someone older or younger.

The important point for applying the principles above is that decisions are made as impartially as possible, focussing as much as we can on who will benefit the most, but being willing to explain how this has been done if there are times when a choice with sound clinical rationale appears discriminatory.

what can you do?

It may seem like these questions are for the Secretary of State for Health, not for the healthcare student! But there is much you can do to help at even the most junior level.

First, learn about the issues. Before Covid, you might never have expected to have to prioritise between individual patients if you stayed in the UK to work. The pandemic has reminded us that even in a well-funded and sophisticated health system, there is not always enough to go round. Hard decisions had to be made both around intensive care in hospital, and hospital admission from the community. That decision maker might be you in not so many years.

Second, consider leadership. As we have seen, in normal circumstances, decisions like these are made at a system level. Why not get involved in

NHS leadership and management so that you can have a voice where decisions are made? Sometimes local bodies that deal with guidelines in individual hospitals, or CCGs in primary care, make significant choices. The NHS is keen to train in leadership,[23] and there are relevant intercalated BSc programmes.

Third, remember that small things matter. How much does the NHS spend on venflons every year, or gloves? Ward consumables may look cheap, but good stewardship of them is significant across a system using huge quantities. Good use of these resources means that there is more to go round, and hence less difficult decisions to make. Later in your career, this is most likely to be felt in prescribing. Do you know the cost difference per year between generic olanzapine, generic olanzapine oro-dispersible tablets, and branded olanzapine tablets (answer in reference)?[24] Even prescribing savings of a few pence per strip of tablets can be massive across the system if applied to a commonly ordered item like amoxicillin or ramipril.

Fourth, look wider. For space reasons, this article has focussed on UK questions, and applies mainly to countries with similar or greater health resources. The global spread of such resources is far from equal, a matter well documented in the past by CMF.[25] Might we work outside the UK for a time, or support someone else to do so? As a future leader, we can argue against recruitment campaigns that target countries which already have fewer doctors than us, and support efforts to train enough staff that we might no longer need to import healthcare professionals to sustain the UK's health system.

conclusion

To sum up, there are decisions to make about resources in even the richest countries. Such allocation should remember the intrinsic worth of individuals. It is likely to be easier to use clinical data and avoid value judgments when making these decisions at a system level. The more efficient the system, the less chance there is of hard decisions between pairs of individuals arising; when these do arise in extreme circumstances, they should be made on clinical grounds, using validated scoring systems as much as possible.

Many in the secular world might agree with much I have written; the distinctive for the Christian is strict avoidance of value judgements on patients' circumstances, the motivation for careful use of resources coming from knowledge that they are God-given. It can sometimes appear as if pursuit of ever more healthcare has become a quest for eternal life itself. We know as Christians that this quest will be fruitless. Eternal life comes only through God's gift in his Son.[26] ■

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